Patient Needs Assessment
Template 1

Request Date:	**New Setup:Yes()No( )**	**Revised:Yes() No( )**
Patient Name	**Last Name:** **First Name:**	
Social Security Number	**SS#:**	
Date of Birth	**DOB:**	
Patient's Address	**Apt:** **Street:** **City:** **State:** **Zip Code:**	
Patient Telephone # + Area Code	**Phone #: ( )**	
Secondary Telephone # (if second line installed for telehealth device use)	**Device Phone # ( )**	
Caregiver Name	**Last Name:** **First Name:**	
Nurse Case Manager Name	**Last Name:** **First Name:** **Phone #:** **E-mail Address:**	
Primary Care Provider Name	**Last Name:** **First Name:** **Phone #:** **E-mail Address:**	
VA Facility	**Facility Name:** **State:** **VA Station**	
Consent Form completed	YES ( )	
Photo Consent Form completed	YES ( )	
Entry Date (mo-dy-yr)		
Termination Date (mo-dy-yr)		
Reason for Termination		
Inclusion Criteria:		
Intact Cognitive Function	YES ( ) NO ( )	
Intact ADLs	YES ( ) NO ( )	
Supportive Other	YES ( ) NO ( )	
Eyesight: Large Font Required ?	YES ( ) NO ( )	
Diagnosis:		
CHF	YES ( ) NO ( )	
COPD	YES ( ) NO ( )	
DM	YES ( ) NO ( )	

Other Diagnosis/Diagnoses	YES ( ) NO ( ) **If yes, identify**:
Patient Profile	Brief Med. History:
Education Module-Selected topics	
CHF	YES ( ) NO ( )
COPD	YES ( ) NO ( )
DM	YES ( ) NO ( )
INTERVENTION GROUP SPECIFIC DATA	**Required Sensors**
Temperature	YES ( ) NO ( ) High Limit: Low Limit: Frequency: QD BID Other__
Blood Pressure	YES ( ) NO ( ) High limit: Low Limit: Frequency: QD BID TID QID
Pulse	YES ( ) NO ( ) High limit: Low Limit: Frequency: QD BID
ECG (Single Lead)	YES ( ) NO ( ) High limit: Low Limit: Frequency: QD Other____
Weight	YES (X) NO ( ) High limit: Low Limit: Frequency: QD Other__
F/S Glucose	YES ( ) NO ( ) High limit: Low Limit: Frequency: QD BID Other

Stethoscope: Heart Sounds	YES ( ) NO ( ) High limit: Low Limit: Frequency: QD BID Other____
Stethoscope: Lung Sounds	YES ( ) NO ( ) High limit: Low Limit: Frequency: QD BID Other____
Pulse Oximetry	YES ( ) NO ( ) High limit: Low Limit: Frequency: QD BID Other____
Disease management education	Disease-specific:
HOME ASSESSMENT	
Telephone: Call Waiting Feature Caller ID Feature	YES ( ) NO ( ) YES ( ) NO ( )
Telephone: DSL	YES ( ) NO ( )
3-Prong Electrical Outlet	YES ( ) NO ( )
3-Prong Outlet **grounded**	YES ( ) NO ( )
Outlet close proximity to device site	YES ( ) NO ( )